7161 07135

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 24

1. PLACE OF DEATH:
COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) X
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Magothy River, Chelsea, Beach X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Prince George
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Seat Pleasant (Carmody Hills)
STREET ADDRESS (If rural, give location) 206--74th Place 16X-2

3. NAME OF DECEASED: (Type or Print) (First) NORDAHL (Middle) A.. (Last) AAS

4. DATE OF DEATH (Month) 8/12 (Day) (Year) 19 54

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Aug.24th,1903
9. AGE last birthday: 50 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Cabinet Maker
10b. KIND OF BUSINESS OR INDUSTRY: Unemployed
11. BIRTHPLACE (State or foreign country): Norway
12. CITIZEN OF WHAT COUNTRY? Norway

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Olga (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) None
16. SOCIAL SECURITY No.: 578-16-6643
17. INFORMANT & ADDRESS: Elizabeth C. Oswald 206--74th Place, Carmody Hills, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 929.8

Immediate cause (a) Drowning
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Acute alcoholic intoxication

19a. DATE OF OPERATION: 2
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY water
21c. (City or town) (County) Anne Arundel 02 (State) Md.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8/12/54 M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☒ 1
21f. HOW DID INJURY OCCUR? Drowned during horse play in water while intoxicated

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE R.W. Fisher M. D.
CHIEF MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED Aug. 13, 195

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 8/18/1954
NAME OF CEMETERY OR CREMATORY Mt.Olivet Cemetery
LOCATION (City, town, or county) (State) Washington, D.C.

DATE REC'D BY LOCAL REG. August 18 1954
REGISTRAR'S SIGNATURE [signature] Deputy Registrar
L. DeAlba mmt.

24. FUNERAL DIRECTOR W.W.Chambers Company, Riverdale, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

RECEIVED
AUG 20 1954
BUREAU V. S.

07136

MARYLAND 7138

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Edgewater
STREET ADDRESS (If rural, give location): Rt. 1 Box 439

3. NAME OF DECEASED (Type or Print): (First) GRACE (Middle) V (Last) Adler

4. DATE OF DEATH: (Month) August (Day) 19 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: Sept. 27 1902

9. AGE last birthday: 51 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Edgewater, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas H. Ireland

14. MOTHER'S MAIDEN NAME: Sarah V. Asquith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ---
(If year, give war or dates of service): ----

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Charles Adler- Son same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1714

Immediate cause (a): Cerebral Hemorrhage — Interval between onset and death: 15 minutes

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b): Carcinoma of Cervix, Metastatic — 2-3 yrs.

(c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-16, 1954, to 8-19, 1954, that I last saw the deceased alive on 8-19, 1954, and that death occurred at 6:45 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Edward L Beck M.D. 4 Locust Gate Drive 8-19-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: August 21 54

NAME OF CEMETERY OR CREMATORY: Hope Chapel Cemetery

LOCATION (City, town, or county) (State): Edgewater, Maryland

DATE REC'D BY LOCAL REG.: August 20, 1954

REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: Ben L. Hopping and Son ADDRESS: Annapolis, Md.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 24 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7162 CERTIFICATE OF DEATH

07137

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fort George G. Meade X
LENGTH OF STAY (in this place): 4 Months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U. S. Army Hospital 50

2. USUAL RESIDENCE (HOME) OF DECEASED: New Castle
STATE: Delaware — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: New Castle 46 X - 3
STREET ADDRESS (If rural give location): 38 Robison Drive, Manor Park ✓

3. NAME OF DECEASED: (Type or Print) (First) Dalton (Middle) Lee (Last) Atkins

4. DATE OF DEATH: (Month) August (Day) 31 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 29 August 1954

9. AGE last birthday: yrs. — IF UNDER 1 YEAR: Months — Days 2 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Dalton Amos Atkins

14. MOTHER'S MAIDEN NAME: Doris Ann David

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no
(If Yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Father

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

761.0
Immediate cause (a) DUE TO: cong. atelectasis — Interval Between Onset And Death: 24 hrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO: hyaline membrane — 24 hrs.
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 29 Aug., 1954, to 31 Aug., 1954, that I last saw the deceased alive on 31 Aug., 1954, and that death occurred at 12:45 p.m. from the causes and on the date stated above.

SIGNATURE: Robert Moore (Degree or title) M.D. ADDRESS: Robert Moore, M.D. Fort Meade, Md. DATE SIGNED: 31 August 54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 1 September 1954
NAME OF CEMETERY OR CREMATORY: Post Cemetery
LOCATION (City, town, or county) (State): Fort George G. Meade, Md.

DATE REC'D BY LOCAL REGISTRAR: 31 Aug 54
REGISTRAR'S SIGNATURE: T. A. GORDON CWO USA

24. FUNERAL DIRECTOR: Chaplain Ritter
ADDRESS: Fort Meade, Md.

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RECEIVED
SEP 3 1954
BUREAU V. S.

7163

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07138

Item 18 Film G171 10-18-54 ans & G172 10-28-54ans

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY A4 MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville X
LENGTH OF STAY (in this place) 4 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hosp. 10

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Somerset
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne
STREET ADDRESS (If rural give location) unknown

3. NAME OF DECEASED: (Type or Print) (First) Lillian (Middle) (Last) Ballard
4. DATE OF DEATH: (Month) Aug (Day) 14 (Year) 1954

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): unknown
8. DATE OF BIRTH: unknown
9. AGE last birthday 33 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.C. 2
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 9 (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Hospital Record

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

936.9

IMMEDIATE CAUSE (A) Laceration of left lung

ANTECEDENT CAUSE (B) DUE TO internal bleedings

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO In all probability cause Accidental (No further information) (C)

INTERVAL BETWEEN ONSET AND DEATH: unknown

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 0
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) Som. (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 14th 1954, to August 14th 1954 that I last saw the deceased alive on August 14th 1954, and that death occurred at 8 P. M, from the causes and on the date stated above.

SIGNATURE Stephen Kemper M. D. ADDRESS Crownsville Md DATE SIGNED 8/16/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) DATE THEREOF 8-23-54 NAME OF CEMETERY OR CREMATORY White Marsh LOCATION (City, town, or county) Plymouth, N. C. (State)

DATE REC'D BY LOCAL REGISTRAR 8-16-54 REGISTRAR'S SIGNATURE K. M. Joyce
24. FUNERAL DIRECTOR Wm H. James Jr ADDRESS Princess Anne

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

RECEIVED
AUG 23 1954
BUREAU V. S.

MARYLAND 7139 07139

STATE DEPARTMETT OF HEALTH

Dr Rodler

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

M

I

1. PLACE OF DEATH: COUNTY A. A. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place) 10 Yrs. | HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis 10 | STREET ADDRESS (If rural, give location) 5 Maryland Ave.

3. NAME OF DECEASED (Type or Print): (First) Mamie (Middle) Idela (Last) Barrick | DATE OF DEATH (Month) Aug (Day) 4th (Year) 1954

5. SEX F | 6. COLOR OR RACE W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH 3-13-1879 | 9. AGE last birthday 75 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Frederick Co Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Milton A. Stahr | 14. MOTHER'S MAIDEN NAME Alice C. Remsburg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS Mrs Herbert P. Rice 5 Md. Ave. Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420X

Immediate cause (a) arteriosclerotic heartdisease — 2 mo

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerosis general — 21 days

(c) hypertensive vascular disease

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. myocardial failure

19a. DATE OF OPERATION 0 | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-14, 1954, to 8-4, 1954, that I last saw the deceased alive on 8-4, 1954, and that death occurred at 150A m., from the causes and on the date stated above.

SIGNATURE Edith Roller (Degree or title) M.D. ADDRESS 45 Franklin St Annapolis Md DATE SIGNED 8-4-54

23. BURIAL, CREMATION OR REMOVAL (Specify) Buried | DATE 8-7-54 | NAME OF CEMETERY OR CREMATORY Mt Hope Cem | LOCATION (City, town, or county) Woodsboro (State) Md

DATE REC'D BY LOCAL REG. August 4, 1954 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR M.P. Eichison Son ADDRESS Frederick Md

RECEIVED
AUG 6 1954
BUREAU V. S.

MARYLAND 7140

07140

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

C

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, 10
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elvalton Rural
STREET ADDRESS (If rural, give location) Box 236 Millersville, Post Office

3. NAME OF DECEASED (Type or Print) (First) Baby (Middle) Girl (Last) Bell

4. DATE OF DEATH (Month) August (Day) 20, 19, (Year) 19 54

5. SEX Girl

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH August 18, 54

9. AGE last birthday — yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Hilliard W. Bell

14. MOTHER'S MAIDEN NAME Ruth Dice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --- (If year, give war or dates of service) ---

16. SOCIAL SECURITY NO. none

17. INFORMANT AND ADDRESS Mr. Hilliard W. Bell Father same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity 24 wks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/19, 19 54, to 8/20, 19 54, that I last saw the deceased alive on 8/20, 19 54 and that death occurred at 10:40 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) S Bonnick MD ADDRESS Annapolis Md DATE SIGNED 8/20/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE August 21, 54

NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery

LOCATION (City, town, or county) (State) Glen Burnie, Maryland

DATE REC'D BY LOCAL REG. August 21, 1954

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR B3n L.Hopping and Son ADDRESS Annapolis, M.

AUG

MARYLAND

7141

07141

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis, Md. | LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie, Md.
STREET ADDRESS (If rural, give location): Box 55 D.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Douglas	A.	Brooks	8	14	1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
M	W.		1/10/1954	yrs.	7	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Evansville, Ind	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lloyd A. Brooks	Georgia Taidrizk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
		Lloyd A. Brooks Glen Burnie

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute glomerulonephritis	5 days.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive encephalopathy	5 days.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from August 10 1954, to August 14, 1954 that I last saw the deceased alive on August 14, 1954 and that death occurred at 3 05 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Neil H. Sims, MD | 95 Cathedral St., Annapolis | 8/15/54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county, (State)
	8/16/54	Ft. Lincoln	Bladensburg Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
August 16, 1954	[signature]	John M. Taylor & Sons	Annapolis, Md.

MARGIN RESERVED FOR BINDING

AUG 17

7142

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07142
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Bay Ridge Road

3. NAME OF DECEASED: (Type or Print) (First) Robert (Middle) J. (Last) Byrne

4. DATE OF DEATH (Month) Aug. (Day) 15 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify):

8. DATE OF BIRTH: April 26, 1910

9. AGE last birthday: 44 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Architectual Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: James F. Byrne

14. MOTHER'S MAIDEN NAME: Mary McCanirey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Rosalinde N. Byrne Same as #2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) DUE TO Coronary Disease — Interval Between Onset and Death: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office hldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE C. Leonhardt
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
M. D. ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 8/18/54

23. BURIAL, ~~CREMATION~~, REMOVAL (Specify): DATE THEREOF 8-18-1954 NAME OF CEMETERY OR CREMATORY St. Paul Cemetery LOCATION (City, town, or county) Norwich (State) N.Y.

DATE REC'D BY LOCAL REG. August 16, 1954
REGISTRAR'S SIGNATURE J. D. Council
24. FUNERAL DIRECTOR John M. Taylor & Sons
ADDRESS Annapolis, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07143

7143 CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 10
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 23 Calvert St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 23 Calvert St.

3. NAME OF DECEASED: (Type or Print) (First) Allen (Middle) W. (Last) Chew

4. DATE OF DEATH. (Month) 8 (Day) 7 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): M.
8. DATE OF BIRTH: 2-16-1885
9. AGE last birthday: 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: U.S. Naval Academy
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James H. Chew
14. MOTHER'S MAIDEN NAME: Mary Etta Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO —
17. INFORMANT & ADDRESS: Annie B. Chew - Annapolis, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO Benign prostatic Hypertrophy — 14 yrs.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic CVD — ?

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/4/54, to 8/7/54 that I last saw the deceased alive on 8/7/54, and that death occurred at 1:50 PM, from the causes and on the date stated above.

SIGNATURE Frank M. Shipley M.D. ADDRESS Annapolis DATE SIGNED 8/7/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 8-11-54
NAME OF CEMETERY OR CREMATORY Brewer Hill
LOCATION (City, town, or county) (State) Annapolis, Md.

DATE REC'D BY LOCAL REGISTRAR 8-9-54
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR William Reese
ADDRESS 11-108 N. Washington St. Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07144

7164 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena
LENGTH OF STAY (in this place) 38 y
HOSPITAL OR INSTITUTION OR STREET ADDRESS Light Street Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Maggie (Middle) O. (Last) Clark
4. DATE OF DEATH: (Month) Aug. (Day) 14 (Year) 1954
5. SEX: F.
6. COLOR OR RACE: White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify): Married
8. DATE OF BIRTH: 12/1/94
9. AGE last birthday: 59 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Robinson, A.A. Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Georges Otterbine
14. MOTHER'S MAIDEN NAME: Laura V. Davis
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No.
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Mr. Daniel Clark (Husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Diabetes — Interval Between Onset And Death: 5 years.
DUE TO
Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Blind — 4 years.
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/1/54, to Aug. 14, 1954, that I last saw the deceased alive on 8/12/54, 19 , and that death occurred at 3:18 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Gustave H. Faubendus — ADDRESS Glen Burnie, Md — DATE SIGNED 8/14/54

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) DATE THEREOF 8-17-1954 NAME OF CEMETERY OR CREMATORY Cedar Bluff LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REGISTRAR August 16, 1954 REGISTRAR'S SIGNATURE L. J. D'Alba
24. FUNERAL DIRECTOR John M. Taylor & Sons ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

1. PLACE OF DEATH: COUNTY A.A. Co Annapolis MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) 10

LENGTH OF STAY (in this place) 2 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. General Hospital 20

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Wash COUNTY D.C.

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN

STREET ADDRESS (If rural, give location) 1242 U. St S.E.

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) Raymond D. Cleland.

4. DATE OF DEATH (Month) (Day) (Year) 8 3 1954

5. SEX: M.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: July 1, 1926

9. AGE last birthday: 28 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pittsburgh Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Cleland

14. MOTHER'S MAIDEN NAME: Mabel Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Subluxation Cervical Vertebrae

DUE TO

Antecedent cause(s) (b) with Cord injury

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH 8/1/54 TO 8/3/54

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) BEACH.

21c. (City or town) Vista MAGO-Beach. (County) A.A.Co (State) MD

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8 1 54 P M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Diving injury

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE E. Rene Laist

M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 8/3/54.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Aug 6 1954

NAME OF CEMETERY OR CREMATORY Arlington Natl.

LOCATION (City, town, or county) (State) Washington D.C.

DATE REC'D BY LOCAL REG. Aug. 3, 1954

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 517 11th St S.E.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

AUG

MARYLAND 7145

07146

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (In this place): 20
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Odenton
STREET ADDRESS (If rural, give location): Betson Avenue

3. NAME OF DECEASED (Type or Print): (First) HERBERT (Middle) H. (Last) DEARING

4. DATE OF DEATH: (Month) August (Day) 30, (Year) 1954

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: April 29, 1918

9. AGE last birthday: 36 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY: Ft. Geo. G. Meade

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Edward C. Dearing

14. MOTHER'S MAIDEN NAME: Bertha V. Bartley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes — (If year, give war or dates of service) W.W. II

16. SOCIAL SECURITY NO.: 215-09-8304

17. INFORMANT AND ADDRESS: Charles L. Eckman, Odenton, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Uremia — Interval Between Onset and Death: 7 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic Nephritis — 8 years

(c) Diabetes Mellitus — 11 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Coronary Artery Disease — 2 years

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct ..., 1946., to Aug 30 ..., 1954., that I last saw the deceased alive on Aug 30 ..., 1954, and that death occurred at 12:30 A ...m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Edward J Chenoweth M.D. Odenton, Md 8-30-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 9/2/54 — NAME OF CEMETERY OR CREMATORY: Epiphany Cemetery — LOCATION (City, town, or county) (State): Odenton, Maryland

DATE REC'D BY LOCAL REG. 8-31-54 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR — ADDRESS: Wm. Cook, Inc., 1217 St. Paul Street

7165 MARYLAND STATE DEPARTMENT OF HEALTH 07147

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
LENGTH OF STAY (In this place) 2 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Furnace Branch Road.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Savoy (Middle) Gilbert (Last) Dotson
4. DATE OF DEATH (Month) Aug. (Day) 19 (Year) 1954
5. SEX M
6. COLOR OR RACE Colored.
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify) Married
8. DATE OF BIRTH 10/3/10
9. AGE last birthday 43 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Glen Burnie, Md.
12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Daniel C. Dotson
14. MOTHER'S MAIDEN NAME Cordella Brooks
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 216-10-7187
17. INFORMANT AND ADDRESS Mrs. Lillian Dotson (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion — sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22 *I certify that I took charge of the remains described above, held on Autopsy , Inspection X Inquiry X thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes X accident , suicide , homicide , undetermined .*

SIGNATURE Gustave H. Faubert, Md. (Degree or title) Deputy Medical Examiner. ADDRESS Glen Burnie, Md. DATE SIGNED 8/19/54

SPECIAL CREMATION REMOVAL (Specify) Burial
DATE THEREOF Aug 23. 54
NAME OF CEMETERY OR CREMATORY Dotson's Private
LOCATION (City, town, or county) (State) A. A. Co. Md

DATE REC'D BY LOCAL REG. 8/23/54
REGISTRAR'S SIGNATURE J T
24. FUNERAL DIRECTOR James A. Hayes, 638 N. Gilmor St. ADDRESS

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND

7146

07148

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 229 West St.

3. NAME OF DECEASED (Type or Print): (First) Baby (Middle) Boy (Last) Finn

4. DATE OF DEATH: (Month) 8 (Day) 8 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, ~~MARRIED, WIDOWED, DIVORCED~~ (Specify)

8. DATE OF BIRTH: 8-8-1954

9. AGE last birthday yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Annapolis

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Michael Finn

14. MOTHER'S MAIDEN NAME: Gloria Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. Louise Frantum - Arnold, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Anoxia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Central Placenta previa —
(c) Prematurity —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... 19.... to ....., 19.., that I last saw the deceased alive on ....., 19.., and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE Wm. M. Chesney M.D. (Degree or title) ADDRESS 69 Franklin DATE SIGNED 8/13/54

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE 8/13/54 — NAME OF CEMETERY OR CREMATORY Private Burial Ground — LOCATION (City, town, or county) Annapolis Neck, Md. (State)

DATE REC'D BY LOCAL REG. August 13, 1954 — REGISTRAR'S SIGNATURE H. O. Brandt

24. FUNERAL DIRECTOR — ADDRESS John N. Taylor & Sons Annapolis, Md.

AUG 17 19[illegible]
[illegible]

MARYLAND 7166 07149

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. — CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St Margarets — MARYLAND — LENGTH OF STAY (in this place) X — HOSPITAL OR INSTITUTION OR STREET ADDRESS St Margarets Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY A A — CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St Margarets — STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Lawrence Hill (Last) France

4. DATE OF DEATH: (Month) 8 (Day) 19 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED: Widow

8. DATE OF BIRTH: 7-16-1874

9. AGE last birthday: 82 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Md. (Harford)

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Samuel H. Hill

14. MOTHER'S MAIDEN NAME: Naomi Baird

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: A. F. France St Margarets

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Vascular Accident — Interval Between Onset and Death: 24 hr

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic C V D. — yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY: (Month) (Day) (Year) (Hour) — — — m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1/54, to 8/19/54, that I last saw the deceased alive on 8/7/54, and that death occurred at 5 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Frank M Shipley M.D. ADDRESS Annapolis DATE SIGNED 8/20/54

23. ~~BURIAL~~, CREMATION, ~~REMOVAL~~ (Specify): — DATE 8-21-54 — NAME OF CEMETERY OR CREMATORY Ft Lincoln — LOCATION (City, town, or county) Prince Geo Co — (State) Md.

DATE REC'D BY LOCAL REG. August 20, 1954 — REGISTRAR'S SIGNATURE [illegible] — 24. FUNERAL DIRECTOR John M Tayla Sons — ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

AUG
U. S.

07150

7147

MARYLAND STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 83 College Ave

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 83 College Ave

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) E (Last) GATES

4. DATE OF DEATH: (Month) AUGUST (Day) 6, (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 5, 1873

9. AGE last birthday: 81 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman

10b. KIND OF BUSINESS OR INDUSTRY: Md. State Bldg, Annapolis.

11. BIRTHPLACE (State or foreign country): Annapolis.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service): nO

16. SOCIAL SECURITY NO.: nOne

17. INFORMANT AND ADDRESS: Mrs. Annie B. Gates Wife same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause (a) Coronary Thrombosis — Interval between onset and death: 4 weeks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Myocardial Infarction — 4 years

(c) Arteriosclerotic Heart Disease — 1 month

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Gangrene Right Foot

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June ..., 19 54, to Aug 6 ..., 19 54, that I last saw the deceased alive on Aug 6 ..., 19 54, and that death occurred at 8 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): George E. Basil M. D. — ADDRESS: Annapolis Md — DATE SIGNED: 8-8-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: August 9 1954 — NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery — LOCATION (City, town, or county) (State): Annapolis Maryland

DATE REC'D BY LOCAL REG.: August 9, 1954 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: Ben L. Hopping and Son — ADDRESS: Annapolis, Md.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 10 195
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07151

7167

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 2 mos.16 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Deal Island
STREET ADDRESS (If rural give location) Unknown

3. NAME OF DECEASED: (First) John (Middle) (Last) Godwin
4. DATE OF DEATH: (Month) 8 (Day) 25 (Year) 19 54
5. SEX Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 7/4/04
9. AGE last birthday 50 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10B. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Cardio-vascular disease — Known to us since 6/9/54

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Hypertension DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/9, 19 54, to 8/25, 19 54 that I last saw the deceased alive on 8/25, 19 54, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS Crownsville, Md. DATE SIGNED 8/25/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 8/31/54 — NAME OF CEMETERY OR CREMATORY Wattsville — LOCATION (City, town, or county) (State) Wattsville, Va.

DATE REC'D BY LOCAL REGISTRAR 8/26/54 — REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR — ADDRESS Edgar Wharton-New Church, Va.

RECEIVED
AUG 3
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07152

7168 CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY A.A. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE
LENGTH OF STAY (in this place) SINCE 1929
HOSPITAL OR INSTITUTION OR STREET ADDRESS /

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CROWNSVILLE
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) L [redacted] (Last) GRIMES

4. DATE OF DEATH: (Month) 8 (Day) 19 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify):

8. DATE OF BIRTH: 5/26/1911

9. AGE last birthday 43 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): L.P.N

10B. KIND OF BUSINESS OR INDUSTRY: STATE HOSPITAL

11. BIRTHPLACE (State or foreign country): N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILSON LUCAS

14. MOTHER'S MAIDEN NAME: FANNY LUCAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: RELATIVES

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) SPINAL THROMBOSIS

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: SINCE JAN. 1954

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. NONE

19A. DATE OF OPERATION: NONE

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from DEC. 1953 to 8/19 1954, that I last saw the deceased alive on 8/19 1954, and that death occurred at 0010 P M, from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS CROWNSVILLE, MD. DATE SIGNED 8/19/54

23. BURIAL, ~~CREMATION~~, REMOVAL (SPECIFY) DATE THEREOF Aug 21-1954 NAME OF CEMETERY OR CREMATORY St. Pauls Chapel LOCATION (City, town, or county) (State) Crownsville Md.

DATE REC'D BY LOCAL REGISTRAR August 23 1954 REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR John M. Taylor Sons ADDRESS Annap. Md.

AUG
BUREAU V. S.

MARYLAND 7148

07153

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md.
STREET ADDRESS (If rural, give location) 44 Murray Ave

3. NAME OF DECEASED (Type or Print): (First) Helen (Middle) O. (Last) Groves
4. DATE OF DEATH: (Month) 8 (Day) 26 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED: Widow
8. DATE OF BIRTH: Unknown
9. AGE last birthday: About 55 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): N. H.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George H. Hobson
14. MOTHER'S MAIDEN NAME: Bertha M. Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Stewart Hobson, Keene N. H.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio Sclerotic Heart disease	3 years.
	(c) Hypertension	3 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1954, to Aug 25, 1954, that I last saw the deceased alive on Aug 24, 1954, and that death occurred at 6.47 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) George C Braid M. D. ADDRESS Annapolis Md DATE SIGNED 8.26.54

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) DATE 8-27-54 NAME OF CEMETERY OR CREMATORY Arlington National LOCATION (City, town, or county) Arlington (State) Va

DATE REC'D BY LOCAL REG. August 27, 1954
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR John M. Layton Sons ADDRESS Annapolis Md.

RECEIVED
AUG 30 1954
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7169

CERTIFICATE OF DEATH

Reg. Dist. No. 07154 22

1. PLACE OF DEATH.
COUNTY A.A. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS OLD ANNAPOLIS ROAD Clarke Station

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ANNE ARUNDEL
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEVERN
STREET ADDRESS (If rural give location) OLD ANNAPOLIS RD, CLARKE STA.

3. NAME OF DECEASED: (Type or Print) (First) Margaret (Middle) (Last) Hagan

4. DATE OF DEATH (Month) Aug. (Day) 29 (Year) 1954

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) SINGLE
8. DATE OF BIRTH: OCT. 17, 1880
9. AGE last birthday 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): REGISTERED NURSE (RET.)
10B. KIND OF BUSINESS OR INDUSTRY: HOSP. EYE, EAR, NOSE & THROAT
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN HAGEN
14. MOTHER'S MAIDEN NAME: MARY (UNKNOWN)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-22-5320
17. INFORMANT & ADDRESS: MRS. ROSA H. JOHNSON 4169 N. SHERIDAN RD. CHICAGO, ILL

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.

ANTECEDENT CAUSE (S) DUE TO (B) Arterio-Sclerosis — 10 yrs.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A DATE OF OPERATION: 0
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 4, 1954, to Aug 29, 1954, that I last saw the deceased alive on 8/29, 1954, and that death occurred at 2 A. M, from the causes and on the date stated above.

SIGNATURE Chas L Ball Jr. M.D. ADDRESS Linthicum DATE SIGNED 8/29/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL
DATE THEREOF AUG. 31, 1954
NAME OF CEMETERY OR CREMATORY GLEN HAVEN
LOCATION (City, town, or county) (State) GLEN BURNIE, MD

DATE REC'D BY LOCAL REGISTRAR August 30, 1954
REGISTRAR'S SIGNATURE Clara Haslup L. J. De Alba mnt.
24. FUNERAL DIRECTOR T.W. Singleton ADDRESS Glen Burnie, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07155

7170 CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town): GREEN HAVEN
LENGTH OF STAY (in this place): 13 YRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 12 TH STREET

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: MARYLAND COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: GREEN HAVEN
STREET ADDRESS (If rural give location): 12 TH STREET

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) EMMA (Last) HAYES

4. DATE OF DEATH: (Month) AUG. (Day) 1 (Year) 19 54

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: 11/6/1863

9. AGE Last birthday: 90 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): PRACTICAL NURSE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): CHESTER PENN

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: — McCANN

14. MOTHER'S MAIDEN NAME: — EVANS

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT & ADDRESS: LESLIE HAYES - GREEN HAVEN, MD

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic Cardio Vascular Illness DUE TO — Interval Between Onset And Death: 10 yrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAY, 19 54 to AUG. 1, 19 54, that I last saw the deceased alive on JULY 31, 19 54 and that death occurred at 4:10 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title): G. Brady Smith M.D. ADDRESS: Riviera Beach Md. DATE SIGNED: 8/1/54

23. BURIAL, ~~CREMATION~~, REMOVAL (Specify): Burial DATE THEREOF: 8/4/54 NAME OF CEMETERY OR CREMATORY: West Liberty LOCATION (City, town, or county) (State): Md

DATE REC'D BY LOCAL REGISTRAR: 8-2-54 REGISTRAR'S SIGNATURE: A. D. Hedrick

24. FUNERAL DIRECTOR: Wm Cook Inc ADDRESS: 1217 St. Paul St

Dmk

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07156

7171 CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital Annapolis, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harundale, Glen Burnie
STREET ADDRESS (If rural give location): 1328 Howard Road

3. NAME OF DECEASED: (Type or Print) (First) Edward (Middle) Joseph (Last) HATFIELD

4. DATE OF DEATH: (Month) August (Day) 28, (Year) 1954

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 3-15-1884

9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Hatfield

14. MOTHER'S MAIDEN NAME: Rosa Quinn

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes
(If Yes, give war or dates of service): 1905-1942

16. SOCIAL SECURITY No.: 164-16-1965

17. INFORMANT & ADDRESS: Mrs. Anna K. Hatfield, 1328 Howard Road Harundale, Glen Burnie

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset And Death
Immediate cause	(a)	Infarction of Heart, Myocardium 420.1	1 hour
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO	Hypertensive Cardiovascular Disease 440	10 yrs.
	(c) DUE TO		

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 28, 1954, to Aug 28, 1954, that I last saw the deceased alive on Aug 28, 1954, and that death occurred at 11:30 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Richard P. Shapera Lt MC USNR USNH Annapolis 8/28/54

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
DATE THEREOF: SEPT. 1, 1954
NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL
LOCATION (City, town, or county) (State): ARLINGTON VA.

DATE REC'D BY LOCAL REGISTRAR: August 30, 1954
REGISTRAR'S SIGNATURE: Wm. J. French
by [illegible]

24. FUNERAL DIRECTOR: Arlington
ADDRESS: Glen Burnie, Md.

VS. A15

MARYLAND 7172

07157
STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 2

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel | MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn | LENGTH OF STAY (In this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Fort Meade Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn
STREET ADDRESS (If rural, give location) Old Fort Meade Road

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Cleveland (Last) Holbrook
4. DATE OF DEATH: (Month) 8 (Day) 15 (Year) 1954
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug 19-1884
9. AGE Last birthday: 69 yrs. If under 1 year: Months / Days; If under 24 hrs: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: John P. Holbrook
14. MOTHER'S MAIDEN NAME: Adelaide Barnes
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes
16. SOCIAL SECURITY NO.: 216-10-6931
17. INFORMANT AND ADDRESS: Mrs Kathrin A. Holbrook, Severn Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis — Interval between onset and death: 5 yrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma prostate — 5 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 6
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May ..., 1951, to 6-12..., 19.54, that I last saw the deceased alive on 5-12..., 19.54 and that death occurred at 1:30 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Charles R. MacDonald MD — ADDRESS Glen Burnie Md — DATE SIGNED 8-19-54.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: Aug. 19-1954
NAME OF CEMETERY OR CREMATORY: Pilgrim Baron Mem. Park
LOCATION (City, town, or county) (State): Anne Arundel Co. Md

DATE REC'D BY LOCAL REG. 8-16-54
REGISTRAR'S SIGNATURE: Hedrick Dan
24. FUNERAL DIRECTOR: Burgee Funeral Home (Horace F. Burgee)
ADDRESS: 3631 Falls Road Baltimore

7173 MARYLAND STATE DEPARTMENT OF HEALTH 07159

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 78

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 914 Spa Road

3. NAME OF DECEASED (Type or Print) (First) Janie (Middle) B. (Last) Johnson
4. DATE OF DEATH (Month) 8 (Day) 2 (Year) 1954
5. SEX Female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M.
8. DATE OF BIRTH 1-12-1907
9. AGE last birthday 47 yrs. | If under 1 year Months Days | If under 24 hrs Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME B. Brown
14. MOTHER'S MAIDEN NAME Rosie Randall
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Samuel Johnson - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH. | INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myocardial Ins. 6 MONS.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ✓, Inspection ✓, Inquiry ___ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ___, suicide ___, homicide ___, undetermined ___.*

SIGNATURE [signature] (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 8/3/54.

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 8-5-54 | NAME OF CEMETERY OR CREMATORY Brewer Hill | LOCATION (City, town, or county) Annapolis, Md. (State)

DATE REC'D BY LOCAL REG. 8-5-54 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR William Reese, II - 108 W. Washington St. Annapolis, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1907160

7174 CERTIFICATE OF DEATH Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 17 yrs. 3 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) Unknown

3. NAME OF DECEASED: (Type or Print) (First) Wallace (Middle) (Last) Jones

4. DATE OF DEATH: (Month) 8 (Day) 31 (Year) 19 54

5. SEX: M

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1911?

9. AGE last birthday 43? yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Unk.

11. BIRTHPLACE (State or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Wallace Jones

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Respiratory arrest — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Dehydration Catatonia

19A. DATE OF OPERATION: — — — —

19B. MAJOR FINDINGS OF OPERATION — — — — — — — — — — — — — —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — — — — — —

21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? — — — — — — — —

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — — — — M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? — — — — — — — — — —

22. I hereby certify that I attended the deceased from 8/30 ... , 1954 , to ... 8/31/54 ... , that I last saw the deceased alive on ... 8/31 19 ... 54 and that death occurred at 7:15 PM, from the causes and on the date stated above.

SIGNATURE [signature] M. D.

ADDRESS Crownsville, Md.

DATE SIGNED 9/1/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Sept 3 1954

NAME OF CEMETERY OR CREMATORY [illegible]

LOCATION (City, town, or county) (State) [illegible]

DATE REC'D BY LOCAL REGISTRAR Sept 7 1954

REGISTRAR'S SIGNATURE Katherine M. Joyce

24. FUNERAL DIRECTOR [illegible]

ADDRESS [illegible]

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

RECEIVED
SEP 9 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07161

7175 **CERTIFICATE OF DEATH** Reg. Dist. No. 24

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
LENGTH OF STAY (in this place) 4 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Frederick
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Libertytown
STREET ADDRESS (If rural give location) Main St.

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) EDWARD (Last) JOY
4. DATE OF DEATH: (Month) Aug (Day) 17 (Year) 1954

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W
8. DATE OF BIRTH: Feb 3 - 1867
9. AGE last birthday: 87 yrs. If under 1 year: Months Days; If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): [illegible]
10b. KIND OF BUSINESS OR INDUSTRY: [illegible]
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James H Joy
14. MOTHER'S MAIDEN NAME: [illegible] Measel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: none
17. INFORMANT & ADDRESS: Ervin Joy, Libertytown

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral thrombosis — Interval Between Onset And Death: 2 days

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerosis — 15 yrs

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1952, to Aug, 1954, that I last saw the deceased alive on Aug 17, 1954, and that death occurred at 7 pm, from the causes and on the date stated above.
SIGNATURE (Degree or title) [illegible] ADDRESS [illegible] DATE SIGNED [illegible]

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Aug 20 - 1954
NAME OF CEMETERY OR CREMATORY Fairmount
LOCATION (City, town, or county) Libertytown (State) Md
DATE REC'D BY LOCAL REGISTRAR August 20, 1954
REGISTRAR'S SIGNATURE L. J. D'Alba
24. FUNERAL DIRECTOR D. D. Hartzler & Sons ADDRESS Libertytown Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

AUG 13 1934

BUREAU V. S.

2

7176

MARYLAND STATE DEPARTMENT OF HEALTH

07162

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY A.A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DORSEY
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS FORREST AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DORSEY
STREET ADDRESS (If rural, give location) FORREST AVE.

3. NAME OF DECEASED (Type or Print) (First) PEARL (Middle) E. (Last) KING

4. DATE OF DEATH (Month) AUG. (Day) 22 (Year) 1954

5. SEX F.

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH FEB. 16, 1884

9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.

10b. KIND OF BUSINESS OR INDUSTRY O.H.

11. BIRTHPLACE (State or foreign country) BALTIMORE

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME WILLIAM A. RITTER

14. MOTHER'S MAIDEN NAME MARTHA McCULLOUGH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS JAMES R. KING, FORREST AVE, DORSEY AA Co.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Haemorrhage	1 hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized Arterio-sclerosis	3 yrs.
	(c) Diabetes Mellitus	10 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1944, 19....., Aug. 22, 1954, that I last saw the deceased alive on Aug. 22nd, 1954 and that death occurred at 2 P. m., from the causes and on the date stated above.

SIGNATURE Mark Shipley (Degree or title) M.D. ADDRESS Savage Md. DATE SIGNED 8/24/54

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL

DATE THEREOF AUG. 25/54

NAME OF CEMETERY OR CREMATORY MEADOW RIDGE

LOCATION (City, town, or county) (State) DORSEY A.A. CO. MD.

DATE REC'D BY LOCAL REG. 8-24-54

REGISTRAR'S SIGNATURE A W [signature]

24. FUNERAL DIRECTOR Harry H. Nutzle ADDRESS 4101 EDMONDSON AVE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 07163

7177 **CERTIFICATE OF DEATH** Reg. Dist. No. 27

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade
LENGTH OF STAY (in this place) 32 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade
STREET ADDRESS (If rural give location) 14 Lambert Road

3. NAME OF DECEASED: (Type or Print) (First) Albert (Middle) M. (Last) Kistrup
4. DATE OF DEATH: (Month) August (Day) 4 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: March 13, 1897
9. AGE last birthday 57 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): automotive foreman
10B. KIND OF BUSINESS OR INDUSTRY: Government
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) 1917-1919
16. SOCIAL SECURITY NO. 213-22-1981
17. INFORMANT & ADDRESS: Dudley Leizear, 6705 Laurel Drive, Baltimore, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary thrombasis with Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 30 min.

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Probable Arterioscleratic heart disease. — 2 years

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from DOA 19 , to , 19 , that I last saw the deceased alive on , 19 , and that death occurred at M, from the causes and on the date stated above.

SIGNATURE Reuben Gull M. D. ADDRESS Capt. M. C. Fort Meade, Md. DATE SIGNED 5 Aug 54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 9 August 54
NAME OF CEMETERY OR CREMATORY Balto. National Cemetery
LOCATION (City, town, or county) Baltimore (State) Maryland

DATE REC'D BY LOCAL REGISTRAR 5 Aug. 54
REGISTRAR'S SIGNATURE HARRY CARSCH, WOJG USA
24. FUNERAL DIRECTOR Ullrich Funeral Home ADDRESS 4210 Belair Road Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

RECEIVED
AUG 9
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07164 21

7149

CERTIFICATE OF DEATH

Reg. Dist. No. ~~241~~

Anne Arundel County General Hospital

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis Md.
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A.A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Glen Burnie
STREET ADDRESS (If rural give location) Millersville, Box 44 -

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) EBERHART (Last) LARMAN
4. DATE OF DEATH: (Month) AUG. (Day) 8 (Year) 1954

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED
8. DATE OF BIRTH: 1887 May 27th
9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Chicken Business
11. BIRTHPLACE (State or foreign country): Washington, N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MARON LARMAN
14. MOTHER'S MAIDEN NAME: — Trusheim

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT & ADDRESS: Myrtle E. Larman, Box 44 Millersville Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Generalized Carcinomatosis — Interval Between Onset And Death: 8 Mo

DUE TO

Antecedent causes (s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last. (b) Carcinoma of Lung — 1 year

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 1953, to Aug 8, 1954, that I last saw the deceased alive on Aug 8, 19[illegible], and that death occurred at 5 P.M., from the causes and on the date stated above.

SIGNATURE Edward J. Sherrett (Degree or title) M.D. ADDRESS Gambrills Md DATE SIGNED 8-8-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 8/12/54 NAME OF CEMETERY OR CREMATORY Glenwood LOCATION (City, town, or county) Washington, D.C. (State)

DATE REC'D BY LOCAL REGISTRAR Aug. 9. 54 REGISTRAR'S SIGNATURE Carrie F. [illegible] Mrs. J. French
24. FUNERAL DIRECTOR W. W. Chambers Co., ADDRESS Riverdale, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

AUG 12 1954

BUREAU V. S.

Items 18&21 Film 3169 8-26-54 7150

07165

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Annapolis

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Severn River

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Pikesville

STREET ADDRESS (If rural, give location) 3502 Old Court Road

3. NAME OF DECEASED: (Type or Print) (First) RICHARD (Middle) S (Last) MARCUS

4. DATE OF DEATH (Month) August (Day) 8 (Year) 19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Aug 6-1915	39 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
President	L. Marcus Corp.	Baltimore Md	U.S.A.

13. FATHER'S NAME: Louis

14. MOTHER'S MAIDEN NAME: Lena

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No		Ruth Marcus - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Asphyxia due to aspiration of vomitus with	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) obstruction of the pharynx and trachea.	
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)	(State)
	Yacht		Anne Arundel	Md.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
		Aspiration of vomitus during an episode of syncope.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE R. K. Fisher M. D.

CHIEF MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED August 9, 1954

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	8-10-54	Beth Tfiloh	Balto Co	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-10-54	A. W. Hedrick	Jack Lewis Inc	2100 Eutaw Pl

T

7151

07166

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

M

I

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 35 Calvert St.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: A. A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
STREET ADDRESS (If rural, give location): 35 Calvert St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Priscilla McPherson

4. DATE OF DEATH (Month) (Day) (Year): August 2 1954

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S.
8. DATE OF BIRTH: 3-2-1881
9. AGE last birthday: 73 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House (Domestic)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Annapolis
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander McPherson
14. MOTHER'S MAIDEN NAME: Harriett Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: Arastine McPherson - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hypertensive Cardio Vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 20, 1953, to August 2, 1954, that I last saw the deceased alive on August 2, 1954, and that death occurred at 7:50 P.m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title): MD — ADDRESS: Annapolis, Md. — DATE SIGNED: August 4, 1954

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 8-5-54 — NAME OF CEMETERY OR CREMATORY: Brewer Hill — LOCATION (City, town, or county) (State): Annapolis Md.

DATE REC'D BY LOCAL REG.: August 5, 1954 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR: William Reese II - 108 W. Washington St. - Annapolis, Md. — ADDRESS

RECEIVED
AUG 6 1954
DURHAM, N. C.

7152 07167

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel Gen. Hos.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 19 Tarsant St

3. NAME OF DECEASED (Type or Print) (First) Quincy (Middle) (Last) McRR H.

4. DATE OF DEATH (Month) Aug. (Day) 23 (Year) 1954

5. SEX Male
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH July 10, 1894
9. AGE last birthday 60 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Laborer
10b. KIND OF BUSINESS OR INDUSTRY Farmer
11. BIRTHPLACE (State or foreign country) Batesburg S. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Mary Bowman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 214-05-2792
17. INFORMANT AND ADDRESS Margarett Merritt, Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary disease — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. [illegible] CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above held an Autopsy ☐, Inspection ✓, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐*

SIGNATURE [signature] (Degree or title) MD ADDRESS Annapolis Md DATE SIGNED 8/23/54

[illegible] DATE THEREOF Burial Aug 27 1954 NAME OF CEMETERY OR CREMATORY Brewer Hill LOCATION (City, town, or county) Annapolis, Md. (State)

[illegible] BY LOCAL REG. August 24, 1954 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR J.B. Johnson, Annapolis, Md. ADDRESS

MARGIN RESERVED FOR BINDING

[illegible] WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED
AUG 23 1
Bulletin U. S.

7153

07168

MARYLAND

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY Anne Arundel General Hosp MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md
LENGTH OF STAY (in this place) 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Ethel (Middle) Mae (Last) Miller

4. DATE OF DEATH (Month) Aug (Day) 1 (Year) 1954

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH March 28 1889

9. AGE last birthday 65 yrs. If under 1 year Months. If under 1 year Days. If under 24 hrs. Hours. If under 24 hrs. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Prince Geo Co Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George T Smith

14. MOTHER'S MAIDEN NAME Jessie Acton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY NO. (If year, give war or dates of service)

17. INFORMANT AND ADDRESS 1304 ODE PL APT 512 Howard M Smith ARL. Co. VA.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Applastic Anemia (Idiopathic) — Interval between onset and death: 2 mon

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c) arteriosclerotic CVD — 3 ? yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) —m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/25, 1954, to 8/1, 1954, that I last saw the deceased alive on 8/1, 1954, and that death occurred at 4:05 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Frank M Shipley M.D. Annapolis Md 8-1-54

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE Aug 4 1954 — NAME OF CEMETERY OR CREMATORY Forestville Md — LOCATION (City, town, or county) (State) Prince Geo Md

DATE REC'D BY LOCAL REG. Aug. 1, 1954 — REGISTRAR'S SIGNATURE J. E. O'Donnell

24. FUNERAL DIRECTOR Joe F Birch's Sons — ADDRESS 3034 Mt Pleasant Wash DC

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 3 ..
BUREAU V. S.

7178

07169

MARYLAND

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wild Rose Shore X
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS NR Annapolis, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington D.C.
STREET ADDRESS (If rural, give location) 2101 16th St N.W

3. NAME OF DECEASED (Type or Print) (First) Henry (Middle) Field (Last) Midgley

4. DATE OF DEATH (Month) August (Day) 22 (Year) 19 54

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Nov 10, 1886

9. AGE last birthday 67 yrs. If under 1 year Months. Days. If under 24 hrs. Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman

10b. KIND OF BUSINESS OR INDUSTRY Industrial Blowers

11. BIRTHPLACE (State or foreign country) Mass.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Leonard Midgley

14. MOTHER'S MAIDEN NAME Clark (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No No

16. SOCIAL SECURITY NO. 050-10-3194

17. INFORMANT AND ADDRESS Mrs Clayds Midgley - Wife - same as # 2.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Myocardial infarction — Interval between onset and death: 1 minute

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Heart Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1951, to Aug 23 1954, that I last saw the deceased alive on Aug 21, 1954, and that death occurred at 11 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) M.D. ADDRESS 8641 Colesville Rd Silver Spring Md DATE SIGNED Aug 23 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Removal DATE August 25 54

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State) Worcester, Massachusetts

DATE REC'D BY LOCAL REG. August 23, 1954

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR B L Hopping & Son ADDRESS Annapolis, Md.

AUG
V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07170

7179 **CERTIFICATE OF DEATH** Reg. Dist. No. 27

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G. Meade ✓
LENGTH OF STAY (in this place) 10 Months
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Pennsylvania COUNTY Allegheny
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Clairton
STREET ADDRESS (If rural give location) 611 Farnsworth Avenue

3. NAME OF DECEASED: (Type or Print) Twin I (First) Baby (Middle) Boy (Last) Moravitz

4. DATE OF DEATH: (Month) August (Day) 12 (Year) 19 54

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: August 12, 1954
9. AGE last birthday: yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 5 Min. –

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): –
10b. KIND OF BUSINESS OR INDUSTRY: –
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Harvey Henry Moravitz
14. MOTHER'S MAIDEN NAME: Toyako Yoshikawa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) –
16. SOCIAL SECURITY No.: –
17. INFORMANT & ADDRESS: Father – Harvey H. Moravitz 101 Wills Avenue, Glen Burnie, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity (wt. 11½ oz) ♂ — Interval Between Onset And Death 5 hours.
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION –
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) –
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12 Aug, 19 54, to 12 Aug, 19 54, that I last saw the deceased alive on 12 Aug, 19 54, and that death occurred at USAH FGGM, from the causes and on the date stated above.
SIGNATURE Alex Friedman (Degree or title) 1/Lt MC. 8:00 A.M. ADDRESS USAH DATE SIGNED Ft George Meade, Md.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 12 August 54
NAME OF CEMETERY OR CREMATORY Post Cemetery
LOCATION (City, town, or county) (State) Fort George G. Meade, Maryland
DATE REC'D BY LOCAL REGISTRAR 12 August 54
REGISTRAR'S SIGNATURE Harry Carsch HARRY CARSCH, WOJG USA
24. FUNERAL DIRECTOR Chaplain Ritter ADDRESS Fort Meade, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 16 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 07171

7180 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort George G. Meade X
LENGTH OF STAY (in this place) 10 Months
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Pennsylvania COUNTY Allegheny
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Clairton
STREET ADDRESS (If rural give location) 611 Farnsworth Avenue

3. NAME OF DECEASED: (Type or Print) Twin II (First) Baby (Middle) Girl (Last) Moravitz

4. DATE OF DEATH: (Month) August (Day) 12 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: August 12 1954

9. AGE last birthday: yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 5 Min. –

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): –

10b. KIND OF BUSINESS OR INDUSTRY: –

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Harvey Henry Moravitz

14. MOTHER'S MAIDEN NAME: Toyako Yoshikawa

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) –

16. SOCIAL SECURITY No.: –

17. INFORMANT & ADDRESS: Father – Harvey H. Moravit 101 Wills Avenue, Glen Burnie, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity (wt 10 3/4 oz) 7. DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) DUE TO

(c)

Interval Between Onset And Death 5 hrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none 0

19b. MAJOR FINDINGS OF OPERATION –

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) no

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12 Aug 1954, to 12 Aug, 1954, that I last saw the deceased alive on 12 Aug, 1954, and that death occurred at 12 Aug 54, from the causes and on the date stated above.

SIGNATURE Wm Friedman (Degree or title) 8:00 A. M. ADDRESS Fort Meade, Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 12 August 54

NAME OF CEMETERY OR CREMATORY Post Cemetery

LOCATION (City, town, or county) Fort Meade (State) Maryland

DATE REC'D BY LOCAL REGISTRAR 12 Aug 54

REGISTRAR'S SIGNATURE HARRY CARSCH WOJG USA

24. FUNERAL DIRECTOR Chaplain Ritter

ADDRESS Fort Meade, Md.

184273

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 16 195
BUREAU V. S.

7154 07172

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: ANNAPOLIS
COUNTY: ANNE ARUNDEL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: ANNE ARUNDEL GENERAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: MARYLAND COUNTY: ANNE ARUNDEL
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE (RURAL
STREET ADDRESS (If rural give location): 213 GREENWAY ROAD, MARLEY PARK

3. NAME OF DECEASED: (Type or Print) (First) NETTIE (Middle) B (Last) PEMBERTON

4. DATE OF DEATH (Month) AUG (Day) 3 (Year) 1954

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED
8. DATE OF BIRTH: JAN. 26, 1872
9. AGE last birthday: 82 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK (RETIRED)
10B. KIND OF BUSINESS OR INDUSTRY: OWN HOME.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: BILYEW
14. MOTHER'S MAIDEN NAME: HENRIETTA HOOPER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT & ADDRESS: 7124 WILLOWDALE AVE MRS. GLORIA JOHNS, BALTIMORE, 6, MD

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Cerebral Vascular Accident	10± days
~~DUE TO~~ (B)	Gangrene, left foot	5± days
~~DUE TO~~ (C)	Left Hemiplegia	10 days
	Arteriosclerotic C.V.D.	10± yrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. —

19A. DATE OF OPERATION: 0
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/2/, 1954 to 8/3/, 1954, that I last saw the deceased alive on 8/3/, 1954, and that death occurred at 5:30 P M, from the causes and on the date stated above.

SIGNATURE: Frank M. Shipley M.D. ADDRESS: Annapolis DATE SIGNED: 8/5/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
DATE THEREOF: AUGUST 6, 54
NAME OF CEMETERY OR CREMATORY: GLEN HAVEN
LOCATION (City, town, or county) (State): GLEN BURNIE,

DATE REC'D BY LOCAL REGISTRAR: August 6, 1954
REGISTRAR'S SIGNATURE: Wm J. French L. J. D'Albo
24. FUNERAL DIRECTOR: T.W. Dingleton ADDRESS: Glen Burnie, Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

RECEIVED
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07173

7181

CERTIFICATE OF DEATH

Reg. Dist. No. 18

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville X

LENGTH OF STAY (in this place) 2 mo.&2 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Talbot

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels

STREET ADDRESS (If rural give location) - - - - -

3. NAME OF DECEASED: (Type or Print) (First) Edna (Middle) Mae (Last) Peters

4. DATE OF DEATH: (Month) Aug. (Day) 21 (Year) 1954

5. SEX: Fem..

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married.

8. DATE OF BIRTH: 1893

9. AGE last birthday 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: - - - -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Palmer

14. MOTHER'S MAIDEN NAME: Agnes (maiden name unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) --

16. SOCIAL SECURITY NO. ----

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Chronic myocarditis

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized arteriosclerosis

DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH: Known to us aince 6/19/54

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cerebral arteriosclerosis " " "

19A. DATE OF OPERATION: - -

19B. MAJOR FINDINGS OF OPERATION - - -

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - -

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) - -

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) - - M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? - -

22. I hereby certify that I attended the deceased from 6-19, 1954, to 8-21, 1954 that I last saw the deceased alive on 8-20, 1954, and that death occurred at 8:35 M, from the causes and on the date stated above.

SIGNATURE Stephen E. Kramer M.D. ADDRESS Crownsville, Md. DATE SIGNED 8-21-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 8/24/54

NAME OF CEMETERY OR CREMATORY St. Michaels Cem.

LOCATION (City, town, or county) (State) St. Michaels Md.

DATE REC'D BY LOCAL REGISTRAR August 26, 1954

REGISTRAR'S SIGNATURE K. [illegible]

24. FUNERAL DIRECTOR James B. Darkiell ADDRESS Easton Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

AUG
BUDGET

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07174

7182

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 1 yr. 11 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 1006 N. Stricker Street

3. NAME OF DECEASED: (Type or Print) (First) Wells (Middle) (Last) Pinder

4. DATE OF DEATH: (Month) 8 (Day) 1 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH: 12/12/72

9. AGE last birthday 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer's Helper

10B. KIND OF BUSINESS OR INDUSTRY: Huckster

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Henry Clay Pinder

14. MOTHER'S MAIDEN NAME: Isabella Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 12 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Arteriosclerotic heart disease

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized Arteriosclerosis

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/9 ..., 1952, to 8/1, 1954 that I last saw the deceased alive on 8/1, 1954, and that death occurred at 2:00 A.M. from the causes and on the date stated above.

SIGNATURE [illegible] M. D. ADDRESS Crownsville, Md. DATE SIGNED 8/2/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 8-3-54 — NAME OF CEMETERY OR CREMATORY Mt. Zion Cem — LOCATION (City, town, or county) (State) Balto. Co. Md

DATE REC'D BY LOCAL REGISTRAR 8-3-54 — REGISTRAR'S SIGNATURE [illegible] — 24. FUNERAL DIRECTOR Samuel W. Sullivan Jr — ADDRESS Balto Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7183 CERTIFICATE OF DEATH

Reg. Dist. No. 07175 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 4 yr.3mos.10days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 2233 Druid Hill Avenue

3. NAME OF DECEASED: (Type or Print) (First) Dunklin (Middle) (Last) Richburg
4. DATE OF DEATH: (Month) 8 (Day) 5 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: ? 1902
9. AGE last birthday 52? yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Alabama
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Richburg
14. MOTHER'S MAIDEN NAME: Rose Richburg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) Unk.
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4432

IMMEDIATE CAUSE (A) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSE (S) DUE TO (B) Hypertensive cardiovascular disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A DATE OF OPERATION: - - - - - -
19B. MAJOR FINDINGS OF OPERATION -
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from , 19 ..., to 8/5, 1954, that I last saw the deceased alive on 8/5, 1954, and that death occurred at 12 noon M, from the causes and on the date stated above.

SIGNATURE L Benedict M D. M. D. ADDRESS Crownsville, Md. DATE SIGNED 8/5/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 8-9-54
NAME OF CEMETERY OR CREMATORY Balto. Nat. Am.
LOCATION (City, town, or county) Baltimore Md (State)

DATE REC'D BY LOCAL REGISTRAR 8-9-54
REGISTRAR'S SIGNATURE A W Hedrick
24. FUNERAL DIRECTOR Chas D. Wilson
ADDRESS 1000 Brantly Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

7184 07176

MARYLAND STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn (RFD) X
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Annapolis Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn (RFD)
STREET ADDRESS (If rural, give location) Old Annapolis Road

3. NAME OF DECEASED (Type or Print) (First) Eva (Middle) Irene (Last) Smith
4. DATE OF DEATH (Month) August (Day) 22, (Year) 1954
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH June 11, 1896
9. AGE last birthday 58 yrs. If under 1 year Months. Days If under 24 hrs Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Anne Arundel Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry F. Smith
14. MOTHER'S MAIDEN NAME Everline Dunner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None.
17. INFORMANT AND ADDRESS Mrs. W. D. Carr - Crownsville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Coronary Thrombosis - suddenly

2X Antecedent cause(s) (b) Chronic Pulmonary Tuberculosis 10 years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Malnutrition.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) (COUNTY) (STATE) —
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Aug 20-54, 19..., to Aug 20-54, 19..., that I last saw the deceased alive on Aug 20-54, 19..., and that death occurred at 2 AM m., from the causes and on the date stated above.

SIGNATURE Joseph Lipshay (Degree or title) M D Odenton Md ADDRESS DATE SIGNED Aug 23-54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Aug. 25, 1954
NAME OF CEMETERY OR CREMATORY Friendship Cemetery
LOCATION (City, town, or county) Anne Arundel Co. (State) Md

DATE REC'D BY LOCAL REG. August 23, 1954
REGISTRAR'S SIGNATURE Clara Hachup
24. FUNERAL DIRECTOR R V Singleton, Glen Burnie, Md. ADDRESS

L J D'Alba mmb.

MARGIN RESERVED FOR BINDING

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07177

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

M

I

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 1 Y
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Millersville
STREET ADDRESS (If rural, give location): Box 174 Crain Highway

3. NAME OF DECEASED (Type or Print): (First) William (Middle) (Last) Smith

4. DATE OF DEATH: (Month) August (Day) 17 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 2/25/1877

9. AGE last birthday: 77 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter - Supt. - Bet

10b. KIND OF BUSINESS OR INDUSTRY: unknown

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Smith

14. MOTHER'S MAIDEN NAME: Anne Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: 213-01-2049

17. INFORMANT AND ADDRESS: Thomas W. Smith, Glen Burnie, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial infarction — Interval Between Onset and Death: minutes

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic C.V.D — 7 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN) (COUNTY) (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to 8/17/1954, that I last saw the deceased alive on 8/17, 1954, and that death occurred at 6:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Frank M. Shipley M.D. — ADDRESS: Annapolis — DATE SIGNED: 8/17/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 8/20/54 — NAME OF CEMETERY OR CREMATORY: Loudon Park — LOCATION (City, town, or county) (State): Balto Md.

DATE REC'D BY LOCAL REG.: Aug 19, 1954 — REGISTRAR'S SIGNATURE: E. D'Albert — Wm. J. French mmt

24. FUNERAL DIRECTOR — ADDRESS: R.V. Singleton Glen Burnie, Md.

AUG 3 1971
BUREAU V. S.

MARYLAND 7156 07178 STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md; MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A.A Co.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md.; STREET ADDRESS (If rural, give location) 1316 Bay Ridge Ave

3. NAME OF DECEASED (Type or Print): (First) ARTRIDGE; (Middle) CAROLINE; (Last) STOKES

4. DATE OF DEATH: (Month) 8; (Day) 18; (Year) 1954

5. SEX: F

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 8/4/1878

9. AGE last birthday: 76 yrs.; If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U S A

13. FATHER'S NAME: William B. Hall

14. MOTHER'S MAIDEN NAME: Fannie Maria

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs Alvin F. Rehn Ft. Arnold, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage and-

Antecedent cause(s) left hemiplegia

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma Head of Pancreas (c)

INTERVAL BETWEEN ONSET AND DEATH: 6 hours; unknown; Several years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis & Heart Disease

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1954, to Aug 18, 1954, that I last saw the deceased alive on Aug 18, 1954, and that death occurred at 2.00 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) George C Bail M.D. ADDRESS Annapolis Md DATE SIGNED 8-20-54

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) DATE 8/21/54 NAME OF CEMETERY OR CREMATORY Cedar Bluff LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. August 20, 1954

REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR John M. Tyler & Sons ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 24 1954
BUREAU V. S.

7185

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. 07179

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY A.A.Co MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bay R. Dge
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Balto.
STREET ADDRESS (If rural, give location) 1306 Kegeston

3. NAME OF DECEASED: (Type or Print) (First) Joan (Middle) L. (Last) Thompson

4. DATE OF DEATH (Month) 8 (Day) 30 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W.	Single	5.22.42	12 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
		Balto	

13. FATHER'S NAME: Chas. Franklin **14. MOTHER'S MAIDEN NAME:** Anna L.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
NO		Family - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Drowning	Sudden
DUE TO (b)		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH:

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Bay Ridge	21c. (City or town)	(County)	(State)
			A.A.Co	MD

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 8 30 54 P M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☑	21f. HOW DID INJURY OCCUR? Boat turned over

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☑ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 9/1/54.

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
B	9.3.54	Balto. Nat.	Balto.	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-2-54	[signature]	[illegible]	120 S. Fort Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07180

7157 CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Annapolis
LENGTH OF STAY (in this place) 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Roads
STREET ADDRESS (If rural, give location) R.F.D. 3

3. NAME OF DECEASED: (Type or Print) (First) Eleanor (Middle) Dunbar (Last) Scott
4. DATE OF DEATH: (Month) 8 (Day) 24 (Year) 1954
5. SEX: F
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH: Sept 7-1888
9. AGE last birthday: 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Private duty
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Conn.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Qualey
14. MOTHER'S MAIDEN NAME: Ann Schofield
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Mrs Thomas Tyler Annapolis Road R.F.D. 3 Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Vascular Accident	2 Hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Cerebral Arteriosclerosis	unknown
	DUE TO (c) Generalized Arteriosclerosis	unknown

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-24, 1954, to 8-24, 1954, that I last saw the deceased alive on 8-24, 1954, and that death occurred at 8:00 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Edward Beck M.D. 4 Locust Ave Annapolis 8-24-54

23. BURIAL, CREMATION, REMOVAL (Specify): DATE THEREOF 8-27-54
NAME OF CEMETERY OR CREMATORY: Cedar Bluff
LOCATION (City, town, or county) (State): Annapolis Md

DATE REC'D BY LOCAL REG. August 25, 1954
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR: John W. Layton Son
ADDRESS: Annapolis Md.

RECEIVED
AUG 26 19..
BUREAU V. S.

07181

MARYLAND 7186 STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH — COUNTY: A. A. — STATE: MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): South River
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: A. G. Co. Home 60

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): West St.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) William (Last) Turner
4. DATE OF DEATH: (Month) 8 (Day) 21 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED: Widower
8. DATE OF BIRTH: 8-6-1867
9. AGE last birthday: 87 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Blacksmith Ret
10b. KIND OF BUSINESS OR INDUSTRY: Blacksmith
11. BIRTHPLACE (State or foreign country): Prince George Co Md
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: John H. Turner
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS: Woodrow W. Turner Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Arteriosclerosis — unknown

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)..... (c).....

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 21 Aug 1954, to 21 Aug 1954, that I last saw the deceased alive on 8-21 1954, and that death occurred at 2 Am m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Edward L Beck M.D. — ADDRESS 46 Courtgate Ave — DATE SIGNED 8-21-54

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE 8-24-54 — NAME OF CEMETERY OR CREMATORY Nichols Bethel — LOCATION (City, town, or county) Adenton — (State) Md

DATE REC'D BY LOCAL REG. August 23, 1954 — REGISTRAR'S SIGNATURE Edw. Gollerson — 24. FUNERAL DIRECTOR John M. Taylor Sons — ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

AUG
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18. 07182

7158 CERTIFICATE OF DEATH Reg. Dist. No. 21

M

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1

VS. A15—10-53

1. PLACE OF DEATH: COUNTY A.A. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 10 | LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberstone
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Mattie (Middle) (Last) Turner

4. DATE OF DEATH (Month) aug. (Day) 30 (Year) 1954

5. SEX: F | 6. COLOR OR RACE: C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married | 8. DATE OF BIRTH April 15 1894 | 9. AGE last birthday 60 yrs. | IF UNDER 1 YEAR, Months, Days | IF UNDER 24 HRS., Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country) Davidsonville Md. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ? Johnson | 14. MOTHER'S MAIDEN NAME: Deborah Ann Grayson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. ? | 17. INFORMANT & ADDRESS: Joseph H Turner Cumberstone Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Peritonitis c/u — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSE (S) DUE TO (A) Paralytic ileus c/u — 4 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Pulmonary edema — 2 day

DUE TO (C) Arteriosclerotic CVD — yrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes M. — ?

19A. DATE OF OPERATION: — 21 | 19B. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? YES ☒ NO ☐

21A ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1954, to 8/30/1954, that I last saw the deceased alive on 8/30/, 1954, and that death occurred at 6 P.M., from the causes and on the date stated above.

SIGNATURE Frank M Shipley | M.D. | ADDRESS Annapolis | DATE SIGNED 9/3/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Sept. 3, 1954 | NAME OF CEMETERY OR CREMATORY Union | LOCATION (City, town, or county) (State) Davidsonville

DATE REC'D BY LOCAL REGISTRAR Sept. 2, 1954 | REGISTRAR'S SIGNATURE [illegible] C. Brown | 24. FUNERAL DIRECTOR Hardesty Funeral Home | ADDRESS

RECEIVED
SEP 3
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7187 CERTIFICATE OF DEATH

Reg. Dist. No. 07183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Davidsonville Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arun
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills
STREET ADDRESS (If rural give location) Davidsonville Rd.

3. NAME OF DECEASED: (Type or Print) (First) ERNEST (Middle) WILLIAM (Last) WEBER

4. DATE OF DEATH: (Month) August (Day) 11, (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 6, 1891

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Superintendent

10b. KIND OF BUSINESS OR INDUSTRY: Bldg. Construction

11. BIRTHPLACE (State or foreign country): Belleville, Ill

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Weber

14. MOTHER'S MAIDEN NAME: Unknonw

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ----- (If Yes, give war or dates of service) --------

16. SOCIAL SECURITY NO.: 215-16-1856

17. INFORMANT & ADDRESS: Mrs. Freida Weber Wife Same as # 2

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

154X

Immediate cause (a) Generalized Carcinomatosis — Interval Between Onset And Death: 1 Year

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Adeno Carcinoma OF Rectum — 18 Mo

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1952, to Aug. 11, 1954, that I last saw the deceased alive on Aug 10., 1954, and that death occurred at 5 P.M., from the causes and on the date stated above.

SIGNATURE Edward J. Hewett M.D. (Degree or title) ADDRESS Gambrills Md DATE SIGNED 8-12-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF August 14, 54

NAME OF CEMETERY OR CREMATORY All Hallows Cemetery

LOCATION (City, town, or county) (State) Davidsonville, Md.

DATE REC'D BY LOCAL REGISTRAR August 13, 1954

REGISTRAR'S SIGNATURE H M Soyce

24. FUNERAL DIRECTOR Ben L. Hopping and Son ADDRESS Annapolis, Md.

14

VS. A15

RECE
AUG 17
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07184

7188 CERTIFICATE OF DEATH

Reg. Dist. No. ..

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater X

LENGTH OF STAY (in this place) 5 y

HOSPITAL OR INSTITUTION OR STREET ADDRESS Deep Park Rd. Woodland Beach Edgewater, Md. X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Edgewater, Md.

STREET ADDRESS (If rural give location) Woodland Beach

3. NAME OF DECEASED: (Type or Print) (First) Hanna (Middle) Charlotta (Last) Weber

4. DATE OF DEATH: (Month) Aug. (Day) 21 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: DEC. 31, 1875

9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR Months 7 Days 21 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Malmo, Sweden

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lars Larsen

14. MOTHER'S MAIDEN NAME: Unk.

15 WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) 4 No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY No.: —

17. INFORMANT & ADDRESS: Chas. J. Weber - 3415 - 40th Ave. Colmar Manor, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death 6 hours

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arterioscleosis — 10 y

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19...., to ....., 19....., that I last saw the deceased alive on ....., 19...., and that death occurred at 7.30 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) Vincent Gowed M.D. ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF Aug. 25/54 NAME OF CEMETERY OR CREMATORY ~~FORT LINCOLN CEM.~~ Arlington LOCATION (City, town or county) ~~PRINCE GEO. CO.~~ Arlington, MD (State)

DATE REC'D BY LOCAL REGISTRAR August 21, 1954 REGISTRAR'S SIGNATURE Edw. Collinson

24. FUNERAL DIRECTOR Martin W. Hysong Co. ADDRESS 1300 - N St. NW Wash. D.C.

Patient dead on arrival. Coroner's case. Death certificate authorized by Elmer G. Linhardt, M.D. Medical Exam.

I MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

AUG 27
BUREAU V. S.

MARYLAND

7159

07185
STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY Anne Arundel Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis - 10
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Arundel Co Hos. Hosp. 20

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena. X
STREET ADDRESS (If rural, give location) Box 87 Rt 5

3. NAME OF DECEASED (Type or Print) (First) Harvey (Middle) R (Last) Werker,
4. DATE OF DEATH (Month) Aug (Day) 9 (Year) 1954

5. SEX M.
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SEPARATED
8. DATE OF BIRTH March 6-1895
9. AGE last birthday 59 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman
10b. KIND OF BUSINESS OR INDUSTRY Auto
11. BIRTHPLACE (State or foreign country) Indiana.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —
(If year, give war or dates of service) —
16. SOCIAL SECURITY NO. 313-09-7699
17. INFORMANT AND ADDRESS Mrs Cleo Stone Rt 5 Box 87 Pasadena

9

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Massive Pulmonary Hemorrhage	2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinomatosis secondary to	
	(c) Cancer of Lung.	2 yr.

1634

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 0
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) —m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/8/54, 19..., to 8/9/54, 19..., that I last saw the deceased alive on 8/9/54, 19..., and that death occurred at 2-10p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Frank R Shipley M.D. Annapolis, Md. 8/9/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 8-11-54
NAME OF CEMETERY OR CREMATORY Kinmell
LOCATION (City, town, or county) (State) Indiana.

DATE REC'D BY LOCAL REG. 8-10-54
REGISTRAR'S SIGNATURE A W Hendrickson
24. FUNERAL DIRECTOR ADDRESS Cook Inc. 1317 St Paul St.

MARGIN RESERVED FOR BINDING

1

Dr Shipley Film#G169 Item# 9 8/18/54 emf

07186

MARYLAND 7160

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY: Anna Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis, 10 — LENGTH OF STAY (in this place): 30
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Edgewater X
STREET ADDRESS (If rural, give location): Edgewater Post Office

3. NAME OF DECEASED (Type or Print): (First) ERVIN (Middle) (Last) WITT

4. DATE OF DEATH: (Month) August (Day) 9, (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Aug. 15, 1880

9. AGE last birthday: 73 74 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal mine

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.: 402-18-7516

17. INFORMANT AND ADDRESS: Mary E. Witt Wife same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Ventricular Fibrillation — —

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic CVD — yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Bronchiectasis — 1 yr

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/8/, 1954, to 8/9/, 1954, that I last saw the deceased alive on 8/9, 1954, and that death occurred at 1.20 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Frank M Shipley M.D. Annapolis 8/11/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: August 12 1954 — NAME OF CEMETERY OR CREMATORY: Edwards Chapel Cemetery — LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: August 12, 1954 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR: Ben L. Hopping and Son — ADDRESS: Annapolis, Md.

RECEIVED
AUG 13 1954
BUREAU V. S.